Cyclospora

Investigator: ______ Phone number: ______

FOR STATE USE ONLY
Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case
Reviewer initials:
Referred to another state:

CASE

Last name: ______ Date of Birth: __/__/__ Estimated? ☐ Age: ______
First and middle name: ______ Gender: ☐ Female ☐ Male ☐ Other ____
Maiden name: ______ Suffix: ______ Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: __/__/__
Address line: ______ Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed
Zip: ______ City: ______ Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian
State: ______ County: ______
Phone: ( )- - Type: ______ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Long-term care resident: ☐ Yes ☐ No ☐ Unknown Parent/Guardian name: ______
Facility name: ______ Parent/Guardian phone: ( )- - Type: ______

EVENT

Diagnosis date: __/__/__ Onset date: __/__/__
Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown
Outbreak related: ☐ Yes ☐ No ☐ Unknown
Outbreak name: ______
Exposure setting: ______
Epi-linked: ☐ Yes ☐ No ☐ Unk To whom: ______
Location acquired: ☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA ☐ Unknown
State: ______ Country: ______

Healthcare provider information

Last name: ______
First name: ______
Provider title: ☐ ARNP ☐ MD ☐ DO ☐ NP ☐ PA
Facility name: ______
Address line 1: ______
Address line 2: ______
Zip code: ______ City: ______
State: ______ County: ______
Phone : ( )- - Type: ______

LABORATORY FINDINGS

Laboratory: ______ Accession #: ______ Collection date: __/__/__
Date received: __/__/__ Specimen source: ______ Test type: ______
Result type: ☐ Preliminary ☐ Final Result date: __/__/__ Result: ☐ Positive ☐ Negative
Organism: ***Cyclospora*** Serotype:

Laboratory: ______ Accession #: ______ Collection date: __/__/__
Date received: __/__/__ Specimen source: ______ Test type: ______
Result type: ☐ Preliminary ☐ Final Result date: __/__/__ Result: ☐ Positive ☐ Negative
Organism: ***Cyclospora*** Serotype:

Laboratory: ______ Accession #: ______ Collection date: __/__/__
Date received: __/__/__ Specimen source: ______ Test type: ______
Result type: ☐ Preliminary ☐ Final Result date: __/__/__ Result: ☐ Positive ☐ Negative
Organism: ***Cyclospora*** Serotype:

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: _____ Job title: _____

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____

Date worked from: / / Address: _____

Date worked to: / / Zip code: _____

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____

Date removed: / / Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown
Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

Occupation type: _____ Job title: _____

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____

Date worked from: / / Address: _____

Date worked to: / / Zip code: _____

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____

Date removed: / / Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown
Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: _____ Admission date: / / Discharge date: / /

Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): _____

Days hospitalized: _____ Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

CLINICAL INFO & DIAGNOSIS

Symptoms

Diarrhea	☐ Yes ☐ No ☐ Unk	_____ Days/Hours		Fatigue	☐ Yes ☐ No ☐ Unk	_____ Days/Hours	
Nausea	☐ Yes ☐ No ☐ Unk	_____ Days/Hours		Fever	☐ Yes ☐ No ☐ Unk	_____ Days/Hours	
Vomiting	☐ Yes ☐ No ☐ Unk	_____ Days/Hours		Abdominal cramps	☐ Yes ☐ No ☐ Unk	_____ Days/Hours	
Headache	☐ Yes ☐ No ☐ Unk	_____ Days/Hours		Chills	☐ Yes ☐ No ☐ Unk	_____ Days/Hours	
Muscle weakness	☐ Yes ☐ No ☐ Unk	_____ Days/Hours		Loss of appetite	☐ Yes ☐ No ☐ Unk	_____ Days/Hours	
				Weight loss	☐ Yes ☐ No ☐ Unk	Amount _____	

First symptom: Most severe symptom: Date returned to normal activities: / /

TREATMENT

Antibiotics prescribed? ☐ Yes ☐ No ☐ Unknown

Antibiotic:	Antibiotic:	Antibiotic:
Date started: / /	Date started: / /	Date started: / /
Dose:	Dose:	Dose:
Unit: ☐ mg ☐ ml ☐ IU	Unit: ☐ mg ☐ ml ☐ IU	Unit: ☐ mg ☐ ml ☐ IU
# of days:	# of days:	# of days:
# of times a day:	# of times a day:	# of times a day:
Route:	Route:	Route:

RISK FACTORS/TRAVEL

Risk Factors/Travel Information – *In the 14 days prior to onset of symptoms did the case:*

Travel	Travel within Iowa? ☐ Yes ☐ No ☐ Unk	City in Iowa:	Departure date: / /	Return date: / /
	Travel within U.S.? ☐ Yes ☐ No ☐ Unk	State: City:	Departure date: / /	Return date: / /
	Travel outside U.S.? ☐ Yes ☐ No ☐ Unk	Country:	Departure date: / /	Return date: / /

Visit restaurants? ☐ Yes ☐ No ☐ Unknown

If Yes, complete the table below: *County and address are missing from this table*

Establishment name	Address/Zip	Date visited	Foods consumed	Others ill?
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk

Attend Group Gatherings (e.g. weddings, parties)? ☐ Yes ☐ No ☐ Unknown

If Yes, complete the following table:

Location name	Address/Zip	Date visited	Foods consumed	Others ill?
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk

Where did the case purchase groceries in the 14 days before the onset of symptoms:

Store name	Address	City/State/Zip	County	Date purchased
				/ /
				/ /
				/ /

Dietary Information – *In the 14 days prior to onset of symptoms did the case consume the following:*

Fruits and vegetables

Fresh berries: ☐ Yes ☐ No ☐ Unk	From dates consumed: / /	To dates consumed: / /	
List all source/types:	List all brand names:		
Fresh herbs: ☐ Yes ☐ No ☐ Unk	From dates consumed: / /	To dates consumed: / /	
List all source/types:	List all brand names:		
Lettuce: ☐ Yes ☐ No ☐ Unk	From dates consumed: / /	To dates consumed: / /	
List all source/types:	List all brand names:		

Other fruits and vegetables: ☐ Yes ☐ No ☐ Unk From dates consumed: / / To dates consumed: / /

List all source/types: List all brand names:

NOTES: